Testimony of
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on
MEDICARE GOVERNANCE
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SENATE FINANCE COMMITTEE

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Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to discuss our efforts to strengthen and improve Health Care Financing Administration (HCFA) management. I greatly appreciate your support in these efforts and your concern for the management challenges facing Medicare, which will celebrate its 35th birthday this year. I believe we share the goals of increasing flexibility in purchasing and management, maintaining and improving the program's high level of efficiency, and modernizing Medicare's benefits while ensuring access to high-quality, accessible services for all beneficiaries.

The people who work at HCFA care deeply about serving the 39 million senior citizens and people with disabilities who rely on Medicare for health care coverage, and I am very proud of our record of accomplishments. HCFA is the largest health insurer in the nation, providing coverage for some 74 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program, and paying about $368 billion for health care services this year.

For Medicare alone, the agency pays more than $210 billion in claims to some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers each year. We contract with 55 private health insurers to process nearly 1 billion Medicare fee-for-service claims each year, and with 346 private health plans that provide managed care. Innovations we have developed in quality improvement and prospective payment systems that promote efficiency have been widely adopted by other insurers.

We spend less than two percent of Medicare benefit outlays on program management. This compares to Medicare+Choice plan administrative costs that average 11 percent and are sometimes 25 percent or more, and supplemental Medigap plan administrative costs that average 20 percent and are sometimes 40 percent or more. HCFA's administrative costs still compare favorably, even when adjusted to account for differences such as marketing expenses, profits, and other costs that private plans may incur.

Success and Solvency

We also have had solid success in meeting the priorities that I articulated at my 1997 confirmation hearing before this Committee: modernizing and strengthening Medicare, starting with implementation of the Balanced Budget Act of 1997 (BBA); sharpening our focus on fraud, waste, and abuse to ensure that Medicare dollars are spent appropriately; launching the State Children's Health Insurance Program; and, meeting the Year 2000 computer challenge.

- Our National Medicare Education Program is an unprecedented enterprise designed to help Medicare beneficiaries understand Medicare and their options under the Medicare+Choice program, as well as the important new preventive benefits included in the BBA.

- We have implemented the vast majority of provisions in the BBA, which modernizes Medicare and Medicaid and strengthens the solvency of the Medicare Trust Fund.

- We have approved State Children's Health Insurance Program plans for all states and territories and enrolled 2 million children.

- We have made substantial progress in implementing new prospective payment systems for skilled nursing facilities, hospital outpatient departments, and home health care that include incentives to provide care efficiently.

- We have had solid success in fighting fraud, waste, and abuse. Our Medicare payment error rate is down by about half. We have many new tools to prevent improper payments and keep unscrupulous providers out of our programs. And we have a comprehensive program integrity plan in place that will help us bring the payment error rate down further.

- And we achieved this while successfully meeting a daunting Year 2000 computer challenge. Despite many predictions of failure, we met this challenge and in the process developed what our independent verification and validation contractor decided were best practices that they in turn recommended to their other clients.

The BBA and our successes in fighting fraud, waste, and abuse, have together contributed to the strongest projection of Medicare Trust Fund solvency in the program's history. The Part A Hospital Insurance Trust Fund, which was projected to become insolvent in 1999 when President Clinton took office, is instead now projected to remain solvent until 2025.

We have also tackled other long-standing challenges with success -- improving services to beneficiaries, improving nursing home quality, improving financial and contractor management, and creating a more open Medicare coverage determination process. We continue to implement management improvements outlined in the President's FY 2000 and FY 2001 Budgets. This initiative is specifically aimed at improving our internal communication, increasing our flexibility to operate, and perhaps most important, increasing accountability to our constituencies.

- We fostered a new focus on serving beneficiaries in all we do through our new Center for Beneficiary Services. This Center has improved the quality of materials for beneficiaries, and its director is a leading member of our Executive Council, bringing a beneficiary focus to all senior level deliberations. And it has made advances in health promotion, for example, by developing tear-cards for colon cancer awareness posters so beneficiaries can take information with them to help start difficult conversations with physicians. We are already seeing results of this sharper beneficiary focus, with numerous awards for our beneficiary web site, www.medicare.gov, and a high rating for beneficiary services in the 1999 American Customer Satisfaction Index.

- We launched a major initiative to improve nursing home care and safety. We tightened rules, clarified guidance, increased surveyor training, required prompt action on complaints alleging harm to residents, and posted survey results on the Internet, and acted to protect residents in facilities with financial difficulties.

- We greatly improved internal financial management and oversight of claims processing contractors. I am determined to meet the same high accounting standards required of major private corporations. This year, for the first time, we obtained an unqualified audit opinion, which means that auditors determined that our books and records adequately reflect Medicare assets and liabilities. But we intend to do even better. We are developing an integrated financial management system to better coordinate and reconcile contractor data. We consolidated contractor management responsibility by appointing a Deputy Director for Medicare Contractor Management and creating a Medicare Contractor Oversight Board. We are determining payment error rates and developing performance report cards for every contractor. And the President's fiscal 2001 budget includes funding for new positions at contractors and at HCFA to further tighten financial controls and ensure swift, coordinated responses to fraud, waste, and abuse.

- We have made the Medicare coverage determination process open and accountable. Every member of the public can request a national coverage policy decision and submit new data for review by our Medicare Coverage Advisory Committee. Information on the status, evidence, and rationale for all determinations is posted on the Internet. And there are timeliness standards for actions on determination requests.

Preparing for the Future

Building on our success in meeting our goals and tackling longstanding management challenges and, thanks to additional resources Congress provided in 1999 and 2000, we are now eagerly preparing for the future. We are conducting a comprehensive assessment of workforce needs, bringing in new employees with private sector experience, and enhancing training for current staff.

We also are consulting with experts across the country and preparing for structural reforms that Medicare will need to address the demographic and health challenges of this new century. We are pleased to see a bipartisan consensus emerging on the need to modernize and strengthen the program. As we work together to act on this consensus, we must not only ensure that the proposals meet the goals of strengthening and modernizing Medicare, but do not undermine the basic commitment of guaranteed access to high-quality health services that has made Medicare the success that it is.

The President has proposed such a plan. It includes:

- **Adding a voluntary, affordable prescription drug benefit available to all beneficiaries.** No one would design Medicare today without a drug benefit. Pharmaceuticals are essential to modern medicine, and no Medicare modernization package is complete unless it ensures that a comprehensive drug benefit is available and affordable to all beneficiaries, both in Medicare+Choice plans and the traditional fee-for-service program.

- **Improving access to preventive services.** We need to focus more on avoiding problems, instead of paying too much to treat preventable problems after they occur. The President and Congress added several important preventive benefits and eliminated copayments for others in the BBA, but there is much more that we can do to promote access to these services. The President's plan would eliminate all existing cost sharing for preventive services and evaluate coverage of additional preventive services.

- **Creating the Competitive Defined Benefit system** . The President's plan would replace the complicated statutory formula used to pay managed care plans with a payment system based on price competition. For the first time, beneficiaries would shop for a health plan based on its price and quality by paying lower Part B premiums for more efficient plans. Managed care plans would also benefit since their payments would be based on what they bid and, unlike today, they would receive an explicit payment for covering prescription drugs.

- **Using proven private-sector purchasing tools.** Primary care and disease management programs are proven to improve health care outcomes while controlling costs. We also need to use bidding to determine what we pay to suppliers and health plans, rather than fee schedules or formulas that result in payment rates that bear no resemblance to true market value. We know this works in the private sector, and we are seeing substantial savings for both beneficiaries and the program in our competitive bidding demonstrations for medical equipment.

- **Reforming Medicare contracting rules.** The plan would bring Medicare contracting in line with standard contracting procedures used throughout the Federal government. While we are making strides in strengthening oversight of the private insurance companies who, by law, process Medicare claims, the General Accounting Office and HHS Inspector General agree with us that we need an open marketplace so we do not have to rely on a steadily shrinking pool of insurance companies and can use all firms capable of processing claims and protecting program integrity.

- **Dedicating non-Social Security surplus to strengthen Medicare's trust fund.** In addition to modernizing the basic program structure, we must shore up its financing and prepare for the inevitable influx of new beneficiaries as the Baby Boom generation reaches retirement age. The President's plan does so by dedicating $299 billion over 10 years of the on-budget surplus to the program to help extend the solvency of the Hospital Insurance Trust Fund through at least 2030. It makes sense to use the budget surplus to help prepare Medicare for the Baby Boom's retirement, since the surplus was largely generated by the Baby Boom. It also helps contribute towards the President's goal of eliminating the national debt by 2013 because these dollars would be used to buy down debt.

The details of the President's reform plan were outlined last June, in the President's FY 2001 budget, and in legislative language sent to Congress last month. We hope that it serves as the basis for comprehensive reform this year.

Another Medicare reform proposal introduced recently is the Medicare Preservation and Improvement Act of 1999, whose primary sponsors are Senators Breaux and Frist. This plan is

the next iteration of the Breaux/Thomas plan and is, in my view, a significant improvement over that proposal. It no longer raises the age of eligibility for Medicare, restricts assistance for drug coverage to low-income beneficiaries, or includes a home health copay. It also, like the President's plan, injects price competition into Medicare. Its focus on the need for Medicare reform is a contribution to the debate.

We are, however, concerned about the plan's Medicare Board proposal, which I would like to discuss. The Administration also has concerns about its premium support proposal, which would have the effect of increasing premiums for the traditional program from 25 to 47 percent, according to the independent Medicare actuary. The GAO and CRS have also testified that traditional program premiums would increase. The plan would offer a 25 percent subsidy for private drug plans, which neither guarantees that a drug option will be available nor affordable to all beneficiaries, unlike all other Medicare benefits. And the plan merges the Medicare trust funds and caps general revenue for Medicare, causing this new trust fund to become insolvent in 2008, according to the GAO. In contrast, the President's plan would extend the Medicare trust fund's life.

Concerns with a Medicare Board

Given the topic of this hearing, I would like to focus on the Board proposal in the Breaux-Frist plan as well as other options being contemplated by Congress. This Committee has been considering proposals to fundamentally change the administration of Medicare, including a proposal to separate administration of original fee-for-service Medicare from oversight of Medicare+Choice plans, and instituting a new Medicare Board to manage the Medicare program. I believe Congress has been contemplating such changes to solve certain perceived problems with the way Medicare is administered today. These include the desire to insulate Medicare from "politics," and make it function more like a private sector company, make the program more responsive to providers, and to address the perceived conflict of interest that exists for a single agency to run both the fee-for-service and Medicare+Choice programs.

However, I believe that some of these issues can be addressed without an overhaul of Medicare's management, and others are inherent in the running of any major program, so that even the most radical Medicare board would not "solve" them. We can and should build our efforts to adopt the best private sector management practices. We have created the new Medicare Coverage Advisory Committee and Citizens Advisory Panel on Medicare Education to get public and private input on these important topics. Our reform plan would give Medicare additional management tools that would allow it to operate more like a private health plan. And, we continue to explore ways to incorporate both advice and practices that have proven successful in the private sector.

An issue that cannot be solved under either the current structure or a Board is the influence of "politics" on Medicare. Politics are a part of any major public or private institution and no amount of restructuring can change that. In a public program like Medicare, "politics" is part of public accountability. It is appropriate for a public program of Medicare's size and importance to be accountable to beneficiaries and taxpayers through their elected representatives -- Congress and the President.

Furthermore, I do not believe the alleged conflict of interest between fee-for-service and

managed care exists at HCFA. Our "clients" are beneficiaries and the taxpayers who support them. Our goal is to give beneficiaries and taxpayers the best health care for their dollars, whether it be through managed care or the traditional program. We have worked very hard to revise regulations and take other steps to help plans participate in the Medicare+Choice program, and believe managed care is an important option for beneficiaries next to the traditional Medicare program.

For these reasons, I do not think that a Medicare Board is necessary. Moreover, as it is structured in the Breaux-Frist plan, a Board would create significant risks to Medicare. The Board would be a 7 member, independent group, not subject to any civil service rules or "sunshine laws" whose members could only be removed for cause. It would administer the competitive premium system and oversee the operations of all Medicare plans, including enrollment, contract oversight, and beneficiary education; and approve and authorize payments for all plans, including traditional Medicare. HCFA would be reorganized into two divisions: one that runs the new health plan operating Medicare fee-for-service and a second that would manage graduate medical education, Medicaid, the State Children's Health Insurance Program, and other functions. Rather than explicitly modernizing the traditional program, the proposal would have HCFA submit a business plan directly to Congress every year, beginning in 2002, for approval.

The major concern with this Board is accountability. With the Board outside the Executive Branch, the President would have virtually no authority over one of the most important Federal programs. In fact, under the proposal sponsored by Senators Breaux and Frist, the Board and its members would be accountable to no one, including Congress. Seniors and people with disabilities rely on their elected officials to respond to their concerns about the care and service they receive in Medicare. This is an extraordinary change given that Medicare is one of the largest government programs, accounting for up to 11 percent of the federal budget, and is of critical importance to millions of our nation's most vulnerable citizens.

This Board would create its own substantial conflict of interest concerns, both with the Board and with original Medicare. Unlike existing Federal boards, the proposal sponsored by Senators Breaux and Frist would create a Medicare board with virtually no conflict of interest requirements for Board members, such as financial disclosure, limits on any management role or financial interest in regulated entities, or limits on member activities after service. That would allow members to make decisions based on personal financial interests or potential benefits from future employment with regulated plans. The proposal sponsored by Senators Breaux and Frist creates a potential conflict of interest for original Medicare, as well. That is because it gives the program a fixed annual budget and that could create undue incentives to put cost concerns ahead of beneficiary rights, quality concerns, and other oversight obligations.

Finally, a Board would detract from administrative efficiency. One of Medicare's greatest strengths is its very low administrative costs. A Board, however, would need to hire staff to perform many duplicative functions, such as beneficiary education, that the original program would need to continue. Under the proposal sponsored by Senators Breaux and Frist, the Board's staff would be hired outside the Civil Service system, further increasing costs. Above this redundant bureaucracy would be a top-heavy Board with seven highly paid members which would not be more nimble than the current administrative structure. In fact, CRS notes that "Difficulties in administering the program are more likely to arise and produce conflicts more difficult to resolve when a program is divided between two distinct federal entities than when

located within one entity." Such a situation would likely not address the concern that Medicare be more responsive to providers or beneficiaries.

CONCLUSION

In considering how to strengthen and improve Medicare's administration, we must carefully and honestly confront the question of what we are trying to fix. Change for the sake of change does not make the improvements necessary to strengthen and modernize Medicare and its administration. We must modernize Medicare governance with effective reforms: injecting competition into the system; giving HCFA other private sector purchasing tools; contracting reform; and administrative flexibility to manage the program. We must secure stable, adequate funding to manage the program and meet demographic changes. We must continue to improve information technology, staff development, and other infrastructures for effective, efficient management. And we must work together to give Medicare the state-of-the-art management this program, its beneficiaries, providers, and other partners deserves.

Medicare is a complex program and its administration is complex. On any given day, someone will disagree with a decision or feel we were not responsive enough. In the two and a half years that I have been Administrator, HCFA has been the subject of more than 1100 audits and oversight reviews by the General Accounting Office and HHS Inspector General. We receive, on average, more than 700 letters a month from members of Congress, and our contractors receive thousands more. This intense oversight and interest is appropriate, given the billions of dollars at stake and the influence Medicare has on the lives of so many Americans. This is an important point. I believe part of the context for the interest in Medicare governance today has to do with our work implementing the truly historic Balanced Budget Act of 1997, combined with our unprecedented efforts to fight fraud, waste, and abuse.

The BBA represented the agreement of Congress and the Administration to slow the growth in Medicare. Reducing spending by such an unprecedented amount in such a relatively short time was an unequaled challenge. Virtually every hospital, physician, home health agency, skilled nursing facility, durable medical equipment supplier, and other health care provider in the country has been affected, and almost all have seen an impact on their revenues. Such significant change with such an ambitious implementation schedule has created pressures and dissatisfaction. And HCFA, of course, was the face of the BBA for these providers and, as such, the focus of much of their unhappiness.

But the BBA was the right thing to do. Medicare is now solvent through 2025 because of it, and that gives us time to consider other changes that should be made to further strengthen the program for the future. I believe HCFA did a good job, albeit not a perfect job, in implementing the BBA given the time frames, the competing interests of program stakeholders, and the complexity of the changes. The BBA served to put HCFA administration in the spotlight. I do believe, however, that we have done well in implementing the law and remaining true to the law's intent. The past two years have not been easy for us, providers, beneficiaries, or members of Congress, particularly members of this Committee.

Our heightened focus on program integrity also marked a substantial change from past dealings with providers. Moving in just a few short years from relatively lax efforts to a zero tolerance policy on fraud, waste, and abuse has created its own pressures and dissatisfactions, and it has

been challenging for both us and providers.

We are proud of our record of strengthening Medicare for beneficiaries and management of its operations. We are committed to meeting the management challenges that lie ahead. And we are eager to continue working with you to build upon our achievements and further strengthen and modernize this essential program. I thank you again for holding this hearing, and I am happy to answer your questions.

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